

03000006921

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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

APPLICATION FOR FEB 13, 2003 LICENSURE AND/OR EXAMINATION

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. FEES ARE NOT REFUNDABLE.
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME <u>Physician</u>	2. PROFESSION CODE <u>036</u>	3. LICENSURE METHOD <u>Acceptance of Examination</u>	4. FEE <u>\$ 300.00</u>
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B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|--|--|
| <input checked="" type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|--|--|

PART II: Applicant Identifying Information - You must notify the Department of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE <u>Garcia, Anthony Joseph</u>		2. TITLE (e.g., M.D., D.O.S., etc.) <u>M.D.</u>		3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]	
4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY [REDACTED] [REDACTED] [REDACTED]		ZIP CODE [REDACTED]		COUNTY <u>COOK</u>	
5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY <u>1926 W. Harrison St. Apt. 600</u> <u>Chicago, IL</u>		ZIP CODE <u>60612</u>		COUNTY <u>COOK</u>	
6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) <u>N/A</u>				7. MOTHER'S MAIDEN NAME <u>Castor</u>	
8. PLACE OF BIRTH CITY STATE/COUNTRY [REDACTED]		9. DATE OF BIRTH [REDACTED] <u>3</u> Month Day Year		10. AGE <u>29</u> <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work ([REDACTED]) (Area Code) Home: ([REDACTED]) (Area Code)					
12. PREFERRED e-MAIL ADDRESS(ES) (if available) [REDACTED]					

NAME (Last, First, MI)

Garcia, Anthony J

SSN

Profession

Physician

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12

Graduated

High School?

☒ Yes☐ No

Received

OR G.E.D.?

☐ Yes☒ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED

Walnut High School

3. LAST PRELIMINARY SCHOOL LOCATION (City and State)

Walnut, CA

4. DATE OF GRADUATION

0 6 / 1 9 9 1

Month

Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8

Graduated?

☒ Yes☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)

California State

University Los Angeles

LOCATION

(City and State or Country)

Los Angeles, CA

DATES OF ATTENDANCE

FROM

TO

Month/Year

Month/Year

06/92

06/94

TYPE OF DEGREE EARNED

B.S.

University of Utah

Salt Lake City, UT

08/94

05/99

M.D.

FEB 24 95

POST OFFICE BOX 100000

FEB 24 95

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Foreign or Clinical Training)

INSTITUTION NAME

(Post Office Box Only)

LOCATION

(City and State or Country)

DATES OF ATTENDANCE

FROM

TO

Month/Year

Month/Year

7/2000

7/2001

Did You Complete Training?

☒ Yes☐ No

Creighton University

Omaha, NE

University of Illinois Chicago

Chicago, IL

8/2001

9/2002

☒ Yes☐ No☐ Yes☐ No☐ Yes☐ No

FEB 24 95

FEB 24 95

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
Nebraska	Physician	4214	7/2000	Lapsed
State of Current Licensure where you most recently have been practicing.				
Illinois	Physician	125-043788	09/01/2001	Active
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step 1	UT	6/97	Failed
USMLE Step 1	CA	10/97	Passed
USMLE Step 2	CA	8/98	Failed
USMLE Step 2	CA	3/99	Passed
USMLE Step 3	CA	2/2000	Passed

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI):

Garcia, Anthony D.

SS#:

Profession:

Physician

PART VI: Personal History Information (This part must be completed by all applicants)

YES : NO

1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.
3. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.

X

X

X

X

PART VII: Examination Coding Information (This part is for examination applicants only)

Refer to the REFERENCE SHEET enclosed with this application package and complete the following.

- a) CHART II - Select examination(s) you desire and enter Test Codes.

- b) CHART III - Select the examination site you desire and enter Test Center Code

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- c) CHART IV - Find your School of Graduation and enter school code:

--	--	--	--	--	--

- d) Record the number of times you have taken this exam in Illinois or any other state:

--	--

- e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated?

Yes ☐ No ☐**PART VIII: Child Support and/or Student Loan Information** (Every applicant is required by law to respond to the following questions).

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.

Are you more than 30 days delinquent in complying with a child support order?

Yes ☐ No ☒

(NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State, however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State?

Yes ☐ No ☒**PART IX: Certifying Statement**

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Date

2-3-2003

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME LAST FIRST MIDDLE <u>Garcia Anthony Joseph</u>			2. DATE OF BIRTH Month Day Year [REDACTED]	3. SOCIAL SECURITY NUMBER [REDACTED]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [REDACTED]			5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <u>Physician</u> <u>036</u> Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME <u>N/A</u>			7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED <input type="checkbox"/>	8. DATE FORM COMPLETED <u>2-3-2003</u>

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION <u>University of Illinois Chicago</u>		JOB TITLE <u>Physician</u>	
ADDRESS STREET, CITY, STATE, ZIP CODE <u>1819 W. Polk, Room 446</u> <u>Chicago, IL 60612</u>		DESCRIPTION OF DUTIES PERFORMED <u>Anatomic and clinical</u> <u>Pathology</u> <u>Study Pathology</u> <u>Study Medicine</u> <u>Job seeking</u>	
SUPERVISOR NAME <u>Michele Raible</u>			
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From <u>08/01/2001</u> Month Day Year	<u>80</u>		
To <u>02/03/2003</u> Month Day Year	TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
TOTAL TIME WORKED (Year/Month) <u>1 year 6 months</u>			
B. NAME OF BUSINESS / INSTITUTION <u>Creighton University</u>		JOB TITLE <u>Physician</u>	
ADDRESS STREET, CITY, STATE, ZIP CODE <u>601 N. 30th St.</u> <u>Omaha, NE 68131</u>		DESCRIPTION OF DUTIES PERFORMED <u>Anatomic and clinical</u> <u>Pathology</u> <u>Study Pathology</u> <u>Study Medicine</u> <u>Job seeking</u>	
SUPERVISOR NAME <u>William Hunter</u>			
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From <u>07/01/2000</u> Month Day Year	<u>80</u>		
To <u>07/31/2001</u> Month Day Year	TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
TOTAL TIME WORKED (Year/Month) <u>1 year</u>			

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.

1. NAME LAST FIRST MIDDLE <u>Garcia, Anthony Joseph</u>			2. DATE OF BIRTH [REDACTED]	3. SOCIAL SECURITY NUMBER [REDACTED]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [REDACTED]			5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <u>Physician</u> <u>036</u> Profession Name Profession Code	
6. NICKNAMES OR GIVEN SURNAME <u>N/A</u>				
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable) <u>125-043788</u>			8. ISSUANCE DATE <u>09/01/2001</u>	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 19 months of postgraduate clinical training in Anatomic and Clinical Pathology
(Name of Accredited Postgraduate Clinical Training Program)

from 8/2001 to 3/2003 at the following hospital:

Hospital: University of Illinois at Chicago

Number and Street: 820 S. Wood St.

City, State and Zip Code: Chicago, IL 60612

I further certify that at the time of such training the program was accredited by:

- ☒ the Accreditation Council for Graduate Medical Education;
☐ the Accreditation Council on Canadian Graduate Medical Education; or
☐ the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: Michele Raible, M.D.

Signature of Postgraduate Clinical Training Program Director: [REDACTED]

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MAY 2 2003

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CERTIFICATION OF
POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(OPR)

APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.

1. NAME LAST FIRST MIDDLE <u>Garcia, Anthony Joseph</u>	2. DATE OF BIRTH Month Day Year [REDACTED]	3. SOCIAL SECURITY NUMBER [REDACTED]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [REDACTED]	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <u>Physician</u> <u>036</u> Profession Name Profession Code	
6. MARDEN OR GIVEN SURNAME <u>N/A</u>	8. ISSUANCE DATE	
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)		

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 12 months of postgraduate clinical training in Anatomic and Clinical Pathology
(Name of Accredited Postgraduate Clinical Training Program)

from 07/01/2000 to 08/31/2001 at the following hospital:

Hospital: Creighton University
St. Joseph's Hospital

Number and Street: 601 N. 30th St.

City, State and Zip Code: Omaha, NE. 68131

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I further certify that at the time of such training the program was accredited by:

- ☒ the Accreditation Council for Graduate Medical Education;
☐ the Accreditation Council on Canadian Graduate Medical Education; or
☐ the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: W. J. HUNTER MD

Signature of Postgraduate Clinical Training Program Director: [REDACTED]

Date of this Certification: 15 Feb 2003

Telephone No: [REDACTED]

SEAL

Anthony J. Garcia

Student ID: [REDACTED] Birthdate: [REDACTED]

Official Baccalaureate Academic Record

Secondary Schools:
High School Graduation Date: Graduated Jun 1991
Higher Education Institutions:
UC Davis Sep 1983
CSU Los Angeles Jun 1992
Mt San Antonio College Jun 1992
CSU Cal Poly Pomona Jan 1991
Prelim Last 90

Degrees Awarded:
Bachelor of Science
School of Natural & Social Sciences
Major: Biology

Transfer Credit:
HIGHER EDUCATION CREDIT:
BIOL-418 EVOLUTION Summer Quarter 1992 136.00
BIOL-499 UNDERGRAD STUDY Credit/No. Credit

Current	AHRS	EHRS	QHS	QPTS
Cumulative	8.00	8.00	4.00	4.00
BIOL-360 GENERAL ECOLOGY	144.00	144.00	4.00	4.00
BIOL-398 COOP EDUC				

Current	AHRS	EHRS	QHS	QPTS
Cumulative	162.00	162.00	20.00	20.00
BIOL-330 CELL BIOLOGY				
BIOL-357 WRITING FOR BIOL				
BIOL-398 COOP EDUC				

Current	AHRS	EHRS	QHS	QPTS
Cumulative	180.00	180.00	37.00	105.00
BIOL-416 MOLECULAR GENETICS				
CHEM-3018 ORGANIC CHEMISTRY				
CHEM-302A ORGANIC CHEM LAB				

Current GPA: 1.95868

NO ENTRY BELOW THIS LINE

Transfer Credit Applied to Spring Quarter 1993
SUPPLEMENTAL Spring Quarter 1993 12.00

Current	AHRS	EHRS	QHS	QPTS
Cumulative	22.00	22.00	18.00	37.00
BIOL-422 VERTEBRATE BIOLOGY				
BIOL-424 GEN EMBRYOLOGY				
BIOL-440 TAXON ANGIOSPERMS				
CHEM-301C ORGANIC CHEMISTRY				
CHEM-302B ORGANIC CHEM LAB				
MATH-206 CALCULUS I				

Advanced Placement

Current	AHRS	EHRS	QHS	QPTS
Cumulative	214.00	214.00	55.00	142.00
NTRS-300 PHYSIO+NUTR BASES OF FITNESS				
RELS-345 HLTH+WELLNESS WORLD RELIGIONS				

Current	AHRS	EHRS	QHS	QPTS
Cumulative	222.00	222.00	63.00	174.00

Requirements completed for Bachelor of Science
End of Baccalaureate Academic Record

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED, PROHIBITS RELEASE OF THIS TRANSCRIPT INFORMATION TO A THIRD PARTY WITHOUT WRITTEN CONSENT OF THE STUDENT.

FEB 27 2003
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Anthony Joseph Garcia

UNIVERSITY OF UTAH

SALT LAKE CITY, UTAH 84142

Name: GARCIA, ANTHONY JOSEPH
Student ID: [REDACTED]
SSN: [REDACTED]
Birthdate: [REDACTED]

UNIVERSITY OF UTAH DEGREES
Doctor of Medicine
Major in Medicine
Confer Date: May 22, 1999

DEGREES AWARDED BY OTHER INSTITUTIONS
CALIFORNIA STATE UNIVERSITY, LOS ANGELES
LOS ANGELES, CA
Bachelor of Science
June 19, 1994

BEGINNING OF MEDICINE QUARTER-CAREER

Course Description Attempted Units Earned Units Grade

ANAT 601 Gross Anatomy Human Autumn 1994
ANAT 603 Histology
ANAT 605 Embryology
BIO C 605 Medical Biochemistry
Term GPA: 0.000

BIO C 609 Medical Biochemistry Winter 1995
PB MD 634 Medicine & Society
PHSL 603 Medical Physiology
PSYCT 601 Basic Sci Foundation
Term GPA: 0.000

BIO C 610 Medical Biochemistry Spring 1995
GEN 610 Genetics in Medicine
PHSL 604 Endocrinology
Term GPA: 0.000

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Course Description Attempted Units Earned Units Grade

PATH 600 Medical Immunology Autumn 1995
PATH 604 Medical Microbiology
Term GPA: 0.000

ANAT 605 Neuroanatomy Spring 1996
INTMD 701 Intro To Medicine
Term GPA: 0.000

INTMD 702 Intro To Medicine Autumn 1996
PATH 601 General Pathology
PH TX 601 Pharmacology Therapy
Term GPA: 0.000

MD ID 602 Organ Systems Winter 1997
PATH 602 Systemic Pathology
PH TX 604 Pharmacology
Term GPA: 0.000

INTMD 704 Foundations Geriatrics Spring 1997
MD ID 603 Organ Systems
PATH 603 Systemic Pathology
PSYCT 610 Intro Clinical Psychiatry
Term GPA: 0.000

OBST 701 Clerkship Autumn 1997
OB Gyn Clinic
PED 701 Pediatric Clerkship
Term GPA: 0.000

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AN OFFICIAL SIGNATURE IS WHITE WITH A GRAY BACKGROUND

DEPARTMENT OF PROFESSIONAL REGULATION
STATE OF ILLINOIS
320 WEST WASHINGTON ST MED1
SPRINGFIELD, IL 62786



Ralph O. Boren
University Registrar

This document is a copy of the original transcript. It is printed on gray, SCSIP, SASE security paper with the name of the University printed in small type across the top of the document. A raised seal is not provided. When photocopying the word COP should appear. A BLACK ON WHITE OR A COLOR COPY SHOULD NOT BE ACCEPTED.

THIS DOCUMENT MAY BE A CRIMINAL OFFENSE

UNIVERSITY OF UTAH

SALT LAKE CITY UTAH 84142

Name: GARCIA, ANTHONY JOSEPH
 Student ID: [REDACTED]
 SSN: [REDACTED]
 Birthdate: [REDACTED]

Official Transcript

Course	Description	Attempted Units	Earned Units	Grade
ENTMD 720	Clinical Clerkship			Winter 1998
MD ID 714	Topics In Medicine			
PSYCT 720	Psychiatric Clin Clkshp			
Term GPA:	0.000			
ENTMD 718	Family Practice Clkshp			Spring 1998
MD ID 715	Topics In Medicine			
PSYCT 702	Junior Clinical Clkshp			
Term GPA:	0.000			

Course	Description	Attempted Units	Earned Units	Grade
FE MD 7210	Fam Pract Subinternship			Spring 1999
INTMD 7560	Medical Ethics			
NEURO 7910	Clin Clerkship - V A			
PATH 6070	Med Student Research			
Term GPA:	0.000			
Cumulative GPA:	0.000			
Units Attempted:	186.670			
U of U Units Earned:			186.670	
Total Transfer Units:			0.000	
Total Test Credit:			0.000	
Total Other Credit:			0.000	
Cumulative Units:			186.670	

---CAREER SUMMARY---
 Cumulative GPA: 0.000
 Cumulative GPA Units: 0.000
 Units Attempted: 226.000
 U of U Units Earned:
 Total Transfer Units:
 Total Test Credit:
 Total Other Credit:
 Cumulative Units: 226.000

END OF MEDICINE SEMESTER CAREER
 BEGINNING OF NON-CREDIT QUARTER CAREER
 H EDU 47 Cpr Recertification Autumn 1995 0.00 0.00

---CAREER SUMMARY---
 Cumulative GPA: 0.000
 Cumulative GPA Units: 0.000
 Units Attempted: 226.000
 U of U Units Earned:
 Total Transfer Units:
 Total Test Credit:
 Total Other Credit:
 Cumulative Units: 226.000

END OF NON-CREDIT QUARTER CAREER
 End of Transcript

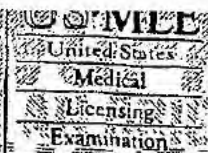
---CAREER SUMMARY---
 Cumulative GPA: 0.000
 Cumulative GPA Units: 0.000
 Units Attempted: 226.000
 U of U Units Earned:
 Total Transfer Units:
 Total Test Credit:
 Total Other Credit:
 Cumulative Units: 226.000

END OF MEDICINE QUARTER CAREER
 BEGINNING OF MEDICINE SEMESTER CAREER
 Quarter to Semester Cum Stats: 150.670 150.670

TH 6070	Med Student Research			Fall 1998
PATH 7020	Clinical Pathology			
PATH 7050	Anatomical Pathology			
Term GPA:	0.000			

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Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 09/11/2001

Illinois Department of Professional Regulation
Alicia Purchase, Section Manager
820 W. Washington St.
3rd Floor, Unit IV
Springfield, IL 62786

Examinee: Garcia, Anthony Joseph
USMLE ID#: [REDACTED]
DOB: [REDACTED]
Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/Fail	Three-Digit		Two-Digit		Comments
			Score	(Passing)	Score	(Passing)	
	10/14/1997	PASS	[REDACTED]		[REDACTED]		Test Accommodations
	6/10/1997	FAIL					
STEP2	Test Date	Pass/Fail	Three-Digit		Two-Digit		Comments
			Score	(Passing)	Score	(Passing)	
	3/2/1999	PASS	[REDACTED]		[REDACTED]		Test Accommodations
	8/23/1998	FAIL					
STEP3	Test Date	Pass/Fail	Three-Digit		Two-Digit		Comments
			Score	(Passing)	Score	(Passing)	
State Board	2/22/2000	PASS	[REDACTED]		[REDACTED]		Test Accommodations

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

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Form 5636874

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

Office of the University Registrar

5151 State University Drive

(323) 343-3840

ACCREDITATION

Cal State L.A. is fully accredited as a four-year degree-granting institution by the Western Association of Schools and Colleges.

COURSE NUMBERING SYSTEM

000-099 Subcollegiate level (no credit allowed toward requirements for academic degrees).

100-299 Lower division courses (freshman and sophomore level)

300-399 Upper division courses (junior and senior level) that do not earn graduate credit

400-499 Upper division courses (junior and senior level) that may earn graduate credit for graduate students.

500-599 Graduate courses for graduate students only.
600-699 Specialized graduate courses for postgraduate students matriculated in the

700-749 Courses intended primarily for lower division students. Not acceptable joint Ph.D. program in Special Education.

toward degree or credential programs but acceptable for professional advancement credit.

750-799 Courses intended primarily for upper division students. Not acceptable toward degree or credential programs but acceptable for professional

800-899 advancement credit. Highly specialized courses intended primarily for graduate students. Not

acceptable toward degree or credential programs but acceptable for professional advancement credit.

RECORDS SYSTEM

All credits are offered beginning Summer 1967 in quarter units. The University operates on a four quarter system. All quarters contributing equally to the academic year which runs from Summer through Spring Quarters.

All Baccalaureate higher education work is incorporated in the Earned Hours (EHRS). A maximum of 105 quarter units from community colleges may be applied toward a bachelor's degree.

GRADING SYSTEM AND GPA CALCULATION

(plus-minus added to grading scheme effective Fall 1996)

	Contributes To	Quality Points	Contributes To	Effective
	Quality Hours	Earned	Earned Hours	Date
A- Superior	Yes	4.0	Yes	
A- Outstanding	Yes	3.7	Yes	
B+ Very Good	Yes	3.3	Yes	
B- Good	Yes	3.0	Yes	
B- Better than Average	Yes	2.7	Yes	
C+ Above Average	Yes	2.3	Yes	
C Average	Yes	2.0	Yes	
C- Below Average	Yes	1.7	Yes	
D- Weak	Yes	1.0	Yes	
D- Poor	Yes	0.7	Yes	
D- Barely Passing	Yes	0.0	Yes	
F Non-Attendance	Yes	0.0	No	
F Unauthorized Incomplete	Yes	0.0	No	
W Withdrawal Unauthorized	Yes	0.0	No	
W Incomplete	No	0.0	No	
I Incomplete Authorized	No	0.0	No	
I Expired Incomplete	Yes	0.0	No	
IC Incomplete Charged	Yes	0.0	No	
SP Satisfactory Progress	No	2.0	No	
RP Report in Progress	No	0.0	No	
W Withdrawn	No	0.0	No	
CR Credit	No	0.0	Yes	
NC No Credit	No	0.0	No	
RD Report Delayed	No	0.0	No	

SHRS (Earned Hours): those hours which earn credit, but may or may not carry

QHRs	(Quality Hours): those hours which carry grade point value
QPTS	(Quality Points): points awarded per course multiplied by the point value of the grade.
GPA	(Grade Point Average) is determined by dividing Quality Points (QPTS) by Quality Hours (QHRs).
Repeat -	Repetition of prior course with lower grade removal from GPA calculation

This educational record is subject to the Educational Rights and Privacy Act of 1974, as amended. It is furnished for official use only and may not be released to or accessed by outside agencies or third parties without the written consent of the student concerned.

THE TRANSCRIPT IS PRINTED ON GREEN SAFETY PAPER AND IS OFFICIAL IF IT BEARS THE SEAL OF THE UNIVERSITY AND THE SIGNATURE OF THE UNIVERSITY REGISTRAR.

The University of Utah

upon the recommendation of the Faculty of
The School of Medicine

has conferred upon
Anthony Joseph Garcia
the Degree of

Doctor of Medicine

with all its Rights, Honors and Responsibilities

In Witness Whereof we have caused the Seal of the University to be affixed this
Twenty-second day of May, One Thousand Nine Hundred Ninety-nine.



Governor of the State of Utah

Chief, Utah State Board of Regents

President of the University

Dean, Faculty of Medicine

Senior Vice President for Health Sciences

Professor, Department of Medicine

CERTIFICATION OF LICENSE

DEPT OF PROFESSIONAL REGULATION
320 W WASHINGTON L & T-1
SPRINGFIELD IL 62786

PROFESSION NAME:		Temporary Educational Permit	
Number:	4214	Status:	Lapsed
Issuance Date:	07/01/2000	Expiration Date:	07/01/2002
Name: Anthony Joseph Garcia MD			
Address: Creighton - Pathology 601 N 30th Street Suite 1609 Omaha NE 68131			
Credential Obtained by:		Application	
Exam Type:			
School/Graduation Date: Univ of Utah School of Med - Salt Lake City 05/22/1999			
Date of Birth:		[REDACTED]	
Place of Birth:		[REDACTED]	
Disciplinary Action:			

To expedite the certification process, the Credentialing Division is using the above format. There is no derogatory information in the professional's records if the Disciplinary Action section above is left blank.

[REDACTED]
Helen L. Meeks, Administrator
Credentialing Division

March 12, 2003

RECEIVED

MAR 18 2003

IDPR-MEDICAL UNIT

You may verify licenses under the following Internet Web Site.
Address: <http://www.hhs.state.ne.us/lis/lis.asp>

APPLICATION TRANSMITTAL - Physician
(This transmittal must accompany the application.)

1. NAME LAST FIRST MIDDLE Garcia, Anthony Joseph				2. DATE OF BIRTH 01-27-1972	3. SOCIAL SECURITY NUMBER [REDACTED]
4. ADDRESS STREET CITY STATE ZIP CODE [REDACTED]				5. REFER TO BOXES A-1 AND A-2 IN PART I ON YOUR APPLICATION FOR LICENSURE/EXAMINATION, Physician 0 3 6 Profession Name Profession Code	

In the area below, indicate whether you have enclosed the 4-page application and the other items listed below or if you have requested an item to be forwarded directly to the Department by another entity (i.e. exam scores).

Enclosed	Requested	Description
X		4-page Application for Licensure and/or Examination
X		Application Fee
X		Form WH (required for all applicants)
		FCVS Physician Profile
	X	TN-MED Form
		ECFMG Certificate (Copy)
X		Medical School Diploma (Copy)
	X	Proof of Pre-Medical and Medical Education (Official transcript of grades issued by medical college or university with school seal affixed) from: <u>California State University Los Angeles</u> <u>University of Utah</u>
		AF-MED
		ED-NON
		5th Pathway/Social Service
		Certification of Licensure (CT) from original and current state of licensure
	X	Exam Scores (Sent directly from USMLE, FLEX, National Board, LMCC or State Board)

The above items are those documents most frequently requested. In the area below, list any other documentation you are submitting with your application that may be required for licensure.

Remarks: _____

Profession: 036

Date: 3/20/2003

Initials: lh

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

To:

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

1	Submit the required fee of \$_____ made payable to the Department of Professional Regulation. This fee is not refundable.	21	Complete AF-MED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s) 1. 2. 3. 4. 5.
2	Your application is being returned for completion of Part _____		
3	Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from _____ to _____	23	Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
4	All documents in a foreign language must be accompanied by original notarized translations by a person other than yourself who is fluent in both English and the language of the document(s). Original documents will be returned to you.	24	The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
5	Submit proof that you are a lawfully admitted alien.	25	Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WH). Use complete dates (mm/dd/yy) and no gaps over 30 days.
6	Have applicable documentation submitted for each positive personal history response. (see attached form)	26	Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
7	When your application is complete, the Medical Licensing Board will review your qualifications.	27	Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
8	Your application will be reviewed by the Medical Licensing Board on _____	28	Have your exam scores forwarded directly from _____
9	Submit completed CA-MED form which indicates beginning and ending program dates.	29	Submit evidence of remedial training.
10	Submit CA-LTD form.	X 30	Submit TN-MED form signed by program director, with seal of hospital.
11	Submit ED-MED form (certification of education).	X 31	University/Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationery must be attached verifying no seal exists.
12	Submit ED-NON form completed in its entirety.	32	Sign Form(s) where indicated
13	Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.	33	Submit certification of original/current licensure (Supporting Document CT) from _____
14	Verification of Pass/Fail Exam History--Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	34	Submit proof that you are board certified in a specialty.
15	Submit official premedical/medical transcript with school seal affixed.	35	Submit restoration questionnaire (Supporting Document RS).
16	Submit photocopy of your degree.	36	Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
17	Submit proof of Titulo or Acta.	37	Returning original documents
18	Submit proof of Social Service or Fifth pathway.	38	Submit proof of 150 CME (minimum 60 CAT I and maximum 90 CAT II)
19	Submit proof of E.C.F.M.G. certification		
20	Submit copy of evaluation form for each of the following core rotations 1. _____ 4. _____ 2. _____ 5. _____ 3. _____		

Other Instructions: Need TN-MED form from University of IL/Chicago.

Profession: 036
Date: 3-4-03 Initials: fa

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

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State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

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2. Your application is being returned for completion of Part _____.	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WH).
5. Submit proof that you are a lawfully admitted alien.	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
7. When your application is complete, the Medical Licensing Board will review your qualifications.	28. Have your _____ scores forwarded directly from _____.
8. Your application will be reviewed by the Medical Licensing Board on _____.	29. Submit evidence of remedial training.
9. Submit completed CA-MED form which indicates beginning and ending program dates.	30. Submit TN-MED form signed by program director, with seal of hospital.
10. Submit CA-LTD form.	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationery must be attached verifying no seal exists.)
11. Submit ED-MED form (certification of education).	32. Sign form(s) where indicated.
12. Submit ED-NON form completed in its entirety.	33. Submit certification of original/current licensure (Supporting Document CT) from <u>NE</u> .
13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.	34. Submit proof that you are Board-certified in a specialty.
14. Verification of Pass/Fail Exam History—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	35. Submit restoration questionnaire (Supporting Document RS).
15. Submit official premedical/medical transcript with school seal affixed.	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
16. Submit photocopy of your degree.	37. Returning original documents.
17. Submit proof of Titulo or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____	

Other Instructions:

#30 - Need TN-MED from Univ of IL/Chicago.
#33 - Need CT from Nebraska.

Profession: DR
 Date: 3-28-03 Initials: JD

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

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State of Illinois
 Department of Professional Regulation
 320 West Washington Street
 MED 1
 Springfield Illinois 62786

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2. Your application is being returned for completion of Part _____.	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WH).
5. Submit proof that you are a lawfully admitted alien.	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
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11. Submit ED-MED form (certification of education).	32. Sign form(s) where indicated.
12. Submit ED-NON form completed in its entirety.	33. Submit certification of original/current licensure (Supporting Document CT) from <u>Nubacha</u> .
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17. Submit proof of Titulo or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____	

Other Instructions:

036 APPLICATION CHECKLIST ENDORSEMENT ACCEPTANCE ✓

APPLICATION FINDINGS

Approved Program ✓ 6-Year
✓ Application Complete
✓ Personal History Yes#

OTHER INFORMATION/NOTES

DOMESTIC GRADUATES

✓ Premedical Transcripts
✓ Medical Transcripts
✓ Diploma Date 5-22-99

FOREIGN GRADUATES

ECFMG/5th Pathway/Social Service
Premedical Transcripts
Translations
Medical Transcripts
Translations
Diploma Date
Translation

6-Year Post Secondary Education

AF-MED Part A
AF-MED Part B
Evaluations: Med Ob/Gyn
Peds Psych Surgery
Affiliations/Contracts

ED-NON Total Months
Core Rotations: Med Ob/Gyn
Peds Psych Surgery

SUPPORTING DOCUMENTS

✓ Work History
Professional Capacity OK ✓
Original Jurisdiction of Licensure
License State & Number NE #
No Discipline
Current Jurisdiction of Licensure
License State & Number
No Discipline

5/2 ✓ Clinical Training 12 or 24 months
Seal ✓ RPD Accredited ✓
Acceptable Examination or Combination
NBME NBOME FLEX
✓ USMLE LMCC State-constructed
American Board Certified
Name Change
✓ Federation Check